BDA Scotland received notification of the Health and Sport Committee Phase 2 of its inquiry into NHS Governance in June 2017. Phase 2 will look at clinical governance which refers to the systems through which NHS organisations are accountable for continuously monitoring and improving the quality of their care and services, and ensuring they safeguard high standards.

NHS Boards are ultimately responsible for ensuring good clinical governance. However, the Quality Strategy sets out the national direction for improving the quality of healthcare. The Scottish Government also published the Governance for Quality Healthcare Agreement in 2013 which sets out the respective roles and responsibilities of the Scottish Government, NHS board personnel and staff. It includes recommended actions in respect of risk management to support the oversight, planning, and delivery of healthcare services. Healthcare Improvement Scotland also has a key role in supporting NHS Boards to develop and maintain effective clinical governance arrangements. It has also led the way in implementing some key national initiatives, for example, the Scottish Patient Safety Programme.

Responses were invited on the questions listed below, and BDA Scotland has answered using responses provided from their members and from the BDA Scotland standing committees.

1. **Are services safe, effective, and evidence-based?**

BDA Scotland would suggest services are not wholly effective. BDA members reported seeing many children from deprived, vulnerable back-grounds requiring general anaesthetic (GA) for multiple teeth extraction. The procedure to refer a child for this procedure is not straight-forward. The child is referred via the SCI Gateway process to paediatric service for assessment, then a second appointment is allocated for anaesthetic assessment and a third appointment for the actual procedure.

SCI gateway and secondary care services are failing children on a daily basis within NHS Greater Glasgow and Clyde.

BDA Scotland would suggest the services are not wholly safe. BDA members also reported child patients attending with pain as an emergency appointment in the interim period of the above mentioned appointments, at which time the pain is managed with antibiotics/analgesics. If there is severe pain/swelling and the child is medically unwell, they can be admitted to hospital, only to have the tooth which is causing the acute problem extracted, the other carious teeth are left to be extracted at a subsequent GA appointment. This is not in the patient’s best interest nor an efficient use of the service.

BDA Scotland would suggest the service is not wholly evidence-based. A referral requires a mandatory CHI number, which is often not available to the general dental practitioner (GDP) and we suggest that the referral process is made easier by removing the mandatory field.
BDA Scotland would highlight that NHS Board managers will opt for purchasing cheaper versions of materials or delay the purchase of equipment to save money despite overwhelming clinical evidence to suggest that some cheaper materials are inferior in quality.

BDA Scotland also notes that managing and investigating complaints about clinicians (ability/knowledge and skills) can take many months with no mechanism to protect patients in the meantime. This, we suggest is unsafe practice.

However, BDA Scotland would suggest that dental services strive to deliver a safe and effective and evidence based service, but there is a gap in terms of direct oversight of individual clinicians’ service delivery and quality of work.

However, BDA Scotland would suggest that dental services strive to deliver a safe and effective and evidence based service, but there is only limited direct oversight of individual clinicians’ service delivery and quality of work.

2. Are patient and service users’ perspectives taken into account in the planning and delivery of services?

BDA Scotland believes that the patient’s perspective is not fully taken into account in planning and delivery of GA extractions particularly for children in deprived areas. These families can lead chaotic lifestyles, and do not attend dental services regularly. English is often not their first language, and many of these families have concerns about engaging with health care professionals. It takes a long time to build-up a rapport with them.

Vulnerable children, who are often non-English speaking, and who require GA treatment for emergency extractions are not being treated effectively.

In NHS Greater Glasgow and Clyde as mentioned under Question 1, a CHI number and school information are both mandatory fields for SCI gateway referral. BDA Scotland would suggest that for emergency referral purposes this is not the most important data field, and the information can be gathered later at a general anaesthetic assessment appointment. The Oral Health Directorate has suggested that dental practices telephone the child’s General Practitioner (GP) in order to obtain the CHI number. BDA Scotland is concerned that there appears to be no governance involved in this decision, and understand that GPs share the same concerns. BDA Scotland is also concerned at the lack of uniformity across the NHS Boards in this regard.

BDA Scotland understands however, that in some NHS Boards there is patient involvement and that individual or group aims are shared, or at least recognised by the health providers who have good insight into what is achievable.

BDA Scotland is also aware that a large section of employees, including senior clinicians, are not consulted over major changes in their workplace.

3. Do services treat people with dignity and respect?

BDA Scotland understands that within NHS Greater Glasgow and Clyde there are cases of children attending Accident and Emergency (A&E) in pain, and having the painful tooth extracted under a GA. This is despite having already been assessed by the paediatric service for a GA prior to attending A&E for extractions. These children then require a further general anaesthetic to have their remaining carious teeth extracted. This is not treating these children with the dignity and respect that is due to them.

BDA Scotland is concerned that there is a lack of engagement by non-clinical staff with experienced clinicians and service providers.
Responses to patient complaints can be delayed and non-specific. Clinicians’ feedback is often ignored and a vague (diplomatic) version of the truth is sent back to patients. BDA Scotland is concerned that generic responses are issued with no intention of dealing with the root of the problem.

BDA Scotland would highlight that it is aware that within other NHS Boards and for other treatments, people are treated with dignity and respect. However, we would note that shared ward situations breach confidentiality as conversations about in depth medical histories are shared.

4. Are staff and the public confident about the safety and quality of NHS services?

Referring to questions 2 and 3 above, BDA Scotland believes that the priority is to provide children with treatment and not spend time on bureaucratic information searching. The system would be easier to operate if CHI referral fields were not mandatory. GDPs are employed as clinicians and not administrators and this is detracting from the quality of care provided.

BDA Scotland would also note that overall staff and the public are confident about safety and the quality of series provided, although this is continually undermined by the media and the quest to apportion blame which undermines trust.

BDA Scotland understands that NHS staff are aware of the gradual deterioration in quality and safety in NHS care and are trying where possible to raise awareness without being penalised for doing so.

5. Do quality of care, effectiveness and efficiency drive decision making in the NHS?

BDA Scotland believes that the quality of care, effectiveness and efficiency do drive decision making in the NHS, however, we would highlight that making changes to improve systems can take a long time to implement.

BDA Scotland would suggest that clinical audits should be taken more seriously and adopted by management teams in all NHS Boards to drive positive change.

6. Are the correct systems in place to detect unacceptable quality of care and act appropriately when things go wrong?

BDA Scotland would highlight that with regard to general dentistry the correct systems are in place to detect unacceptable quality of care and appropriate action is taken when things go wrong. This is dealt with for the General Dental Service (GDS) by the Scottish Dental Reference Service and the Reference Dental Officers in its employ who are good at determining any problems. However, BDA Scotland would highlight that although the Public Dental Service are subject to same checks as those working in the GDS, there is a view that the checks are opportunistic and not targeted, therefore there are no continuous quality systems or checks in dentistry and no remedial work carried out where things go wrong.

BDA Scotland is aware that in hospitals an annual appraisal system is in place, but would question how effective the system has been in highlighting poor performance. BDA Scotland suggests that a clinical review of performance of single-handed clinicians and robust governance structures in rural areas should be considered.

BDA Scotland
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